

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12925 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12921

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R.F.D.3		c. LENGTH OF STAY IN Tb 50 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R.F.D. 3		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie B. Dashiell		First	Middle
4. DATE OF DEATH Nov. 24, 1958		Last	Month Day Year
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1908
9. AGE (in years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Atwood Bozman		14. MOTHER'S MAIDEN NAME Bessie Emory	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-03-59-3	
17. INFORMANT Mr. Elmer Dashiell Princess Anne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		sudden	
DUE TO Acute Coronary Heart Disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None			
DUE TO (c) None			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. H. Johnson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R. H. Johnson, M.D.		DATE SIGNED 11/25/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11-26-1958	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Oriole Cemetery
22d. LOCATION (City, town, or county) Oriole, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Levin R. Wilson		24a. REC'D BY REGISTRAR REC'D 1 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

100-4451

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12926 CERTIFICATE OF DEATH

12922

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		c. LENGTH OF STAY IN 1b 89 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne R.F.D.		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Minnie		First	Middle	Lost	4. DATE OF DEATH Month Nov. 23	Day	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept. 24, 1869	9. AGE (In years lost birthday) 89 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Robert Dashiell		14. MOTHER'S MAIDEN NAME Sallie Waller					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs Fred Kohlheim Princess Anne, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerosis of kidneys (c)						INTERVAL BETWEEN ONSET AND DEATH 7 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a. m. 19 <input type="checkbox"/> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from Nov. 20, 1958, to Nov. 23, 1958, that I last saw the deceased alive on Nov. 23, 1958, and that death occurred at 8 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Everett C. Sutter M.D.						ADDRESS (Street, city or town, state) Dames Quarter, Maryland	
22. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF II-26-1958		22c. NAME OF CEMETERY OR CREMATORIAL All Saint Cemetery		22d. LOCATION (City, town, or county) Venton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lewis R. Wilson		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR DATE DEC 1 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12921
 CERTIFICATE OF DEATH

Reg. Dist. No. 12923

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield		d. STREET ADDRESS 318 Tyler St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 318 Tyler St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First IDA	Middle F.	Last DOWNING	4. DATE OF DEATH	Month November	Day 28	Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 3, 1877	9. AGE (In years from birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Worker		10b. KIND OF BUSINESS OR INDUSTRY Crab & Oyster		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME Robert Gerald				14. MOTHER'S MAIDEN NAME Susan Jones				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Augusta Henry, 2222 Turner St., Phila., Pa.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of Colon</u> DUE TO <u>153.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____								
INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>Nov. 27, 1958</u> to <u>Nov. 28, 1958</u> that I last saw the deceased alive on <u>Nov. 27, 1958</u> , and that death occurred at <u>10:15 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>11/29/58</u>								
ACTUAL SIGNATURE <i>Sarah M. Peyton</i>	M.D. <u>334</u>							
PHYSICIAN'S NAME (Type)	Sarah M. Peyton, M. D. Crisfield, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 30, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Lawsonia Cemetery			22d. LOCATION (City, town, or county) Crisfield, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland	ADDRESS				24a. REC'D BY REGISTRAR DATE DEC 3 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>		

ANNUAL STATEMENT OF THE STATE OF
NEW YORK

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12927 CERTIFICATE OF DEATH

Reg. Dist. No. 12924

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION STATION		d. STREET ADDRESS 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HENRY		First HENRY	Middle G.	Lost ELLIOTT	4. DATE OF DEATH NOVEMBER 26 1958	Month NOVEMBER	Day 26	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1861	9. AGE (In years lost birthday) 97 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME LEVEN ELLIOTT				14. MOTHER'S MAIDEN NAME LAURENE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT NORA WINDSOR		Address MARION STATION, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Terminic Acute Delirium Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Central Nervous DUE TO Chronic Impaired Chancery Senes Chancery								
INTERVAL BETWEEN ONSET AND DEATH 57 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epithelioma of nose duration 10 years								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work						
20c. TIME OF INJURY Hour o. m. p. m.	Month Nov.	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) MARION	(County) MARYLAND	(State) MARYLAND	
21. I certify that I attended the deceased from Nov. 20 , 1958, to Nov. 26 , 1958, that I last saw the deceased alive on Nov. 26 , 1958, and that death occurred at 3:00 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE George C. Coulbourn, M.D.					ADDRESS (Street, city or town, state) MARION, MARYLAND			
DATE SIGNED George C. Coulbourn, M.D.								
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 29, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery		22d. LOCATION (City, town, or county) MARION STATION, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.					ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 3 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

STATE OF CALIFORNIA
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12928

CERTIFICATE OF DEATH

12925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion		d. STREET ADDRESS R.F.D.A. 1. Box 252 A		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION home									
3. NAME OF DECEASED (Type or print) William		First Thomas	Middle Evans	Last Evans	4. DATE OF DEATH November 1, 1958	Month November	Day 1	Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1882		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Sidie Evans		14. MOTHER'S MAIDEN NAME Augusta Tull							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218 14 4027		17. INFORMANT Albert Evans, Marion, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 10 hrs					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.					
c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Essential Hypertension								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Marion		(County) 0	(State) Md.
21. I certify that I attended the deceased from 6/28/58 to 10/31/58 that I last saw the deceased alive on 10/31/58 , and that death occurred at 9:40 AM from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 11 S. 4th St., Brigfield		DATE SIGNED 11-3-58	
ACTUAL SIGNATURE Cecil A. Duvaney M.D.									
PHYSICIAN'S NAME (Type) Edgar Wharton - Newchurch, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Peer		22d. LOCATION (City, town, or county) Marion, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - Newchurch, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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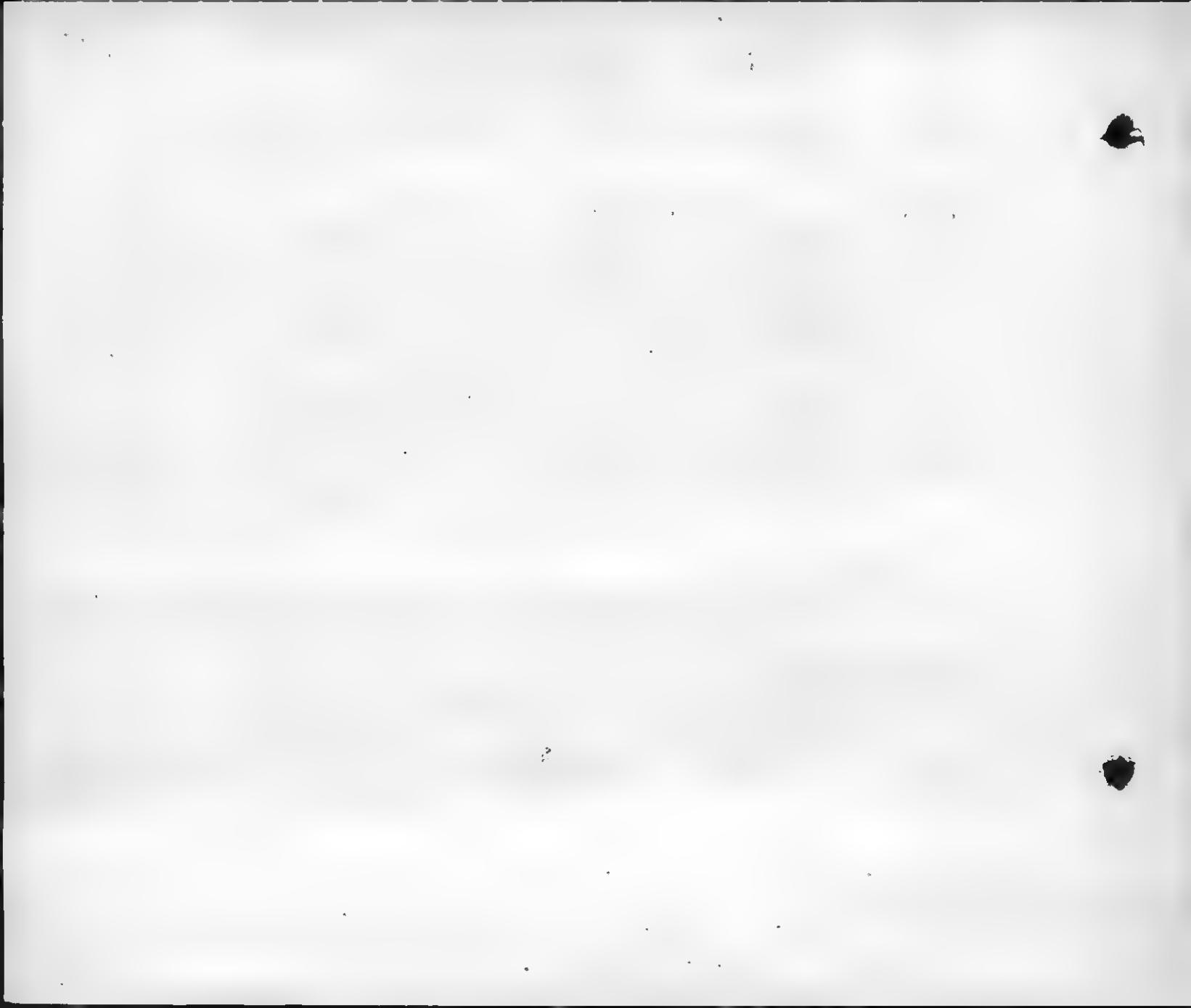
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12929 CERTIFICATE OF DEATH

Reg. Dist. No. **12926**

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION STATION	
3. NAME OF DECEASED (Type or print) HERMAN JASPER FORD		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month NOVEMBER Day 13 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY For Himself	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM FORD		14. MOTHER'S MAIDEN NAME Elizabeth Crosley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) No		16. SOCIAL SECURITY NO. 186-142-448	
17. INFORMANT MARY FORD, MARION, MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Del/Heart Disease 420.1 DUE TO Coronary Constrict INTERVAL BETWEEN ONSET AND DEATH 3 days Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) Chronic Myocarditis Chronic Del myo 80 days DUE TO Chronic Del myo years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) MARION (County) MARYLAND (State) MARYLAND	
21. I certify that I attended the deceased from 10-15 , 1958, to 11-19 , 1958, that I last saw the deceased alive on 11-12 , 1958, and that death occurred at 12:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) MARION, MARYLAND DATE SIGNED George C. Coulbourn, M.D.			
ACTUAL SIGNATURE George C. Coulbourn, M.D. MARION, MARYLAND			
PHYSICIAN'S NAME (Type) G. C. COULBOURN, M.D. MARION, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Sunnuridge Cemetery		22d. LOCATION (City, town, or county) Crisfield, Md. (State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR NOV 17 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Hause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

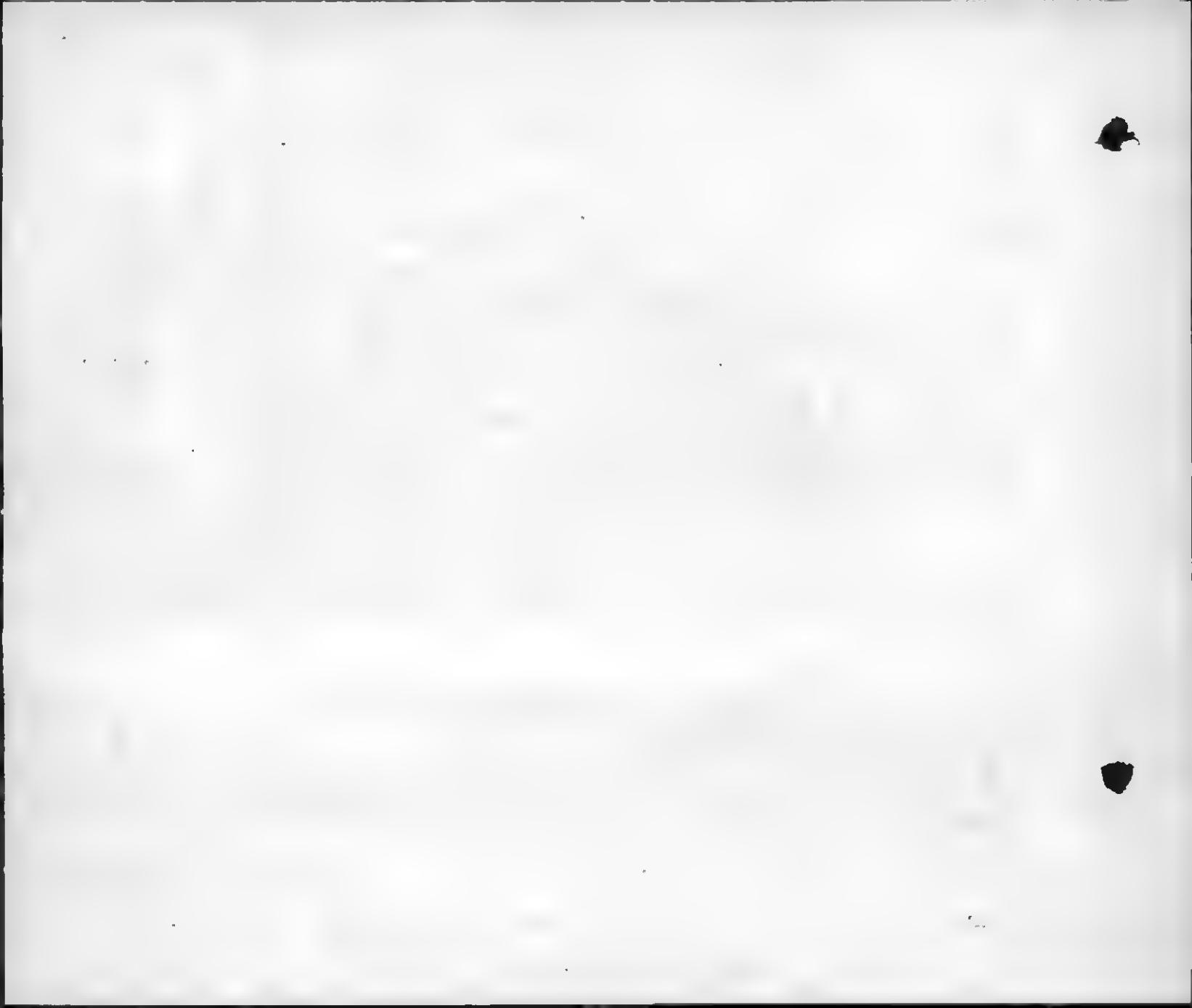
12930

CERTIFICATE OF DEATH

12927

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		b. COUNTY SOMERSET			
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION STATION			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First BLANCHE	Middle BEAN	4. DATE OF DEATH Lost GORDON Month NOVEMBER Day 12 Year 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1889		
9. AGE (In years lost birthday) 69 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY At Home	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES BEAN	14. MOTHER'S MAIDEN NAME ESTELLE KAUFFMAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT FLOYD GORDON	Address MARION, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Cerebral hemorrhage -		INTERVAL BETWEEN ONSET AND DEATH 1 hour -			
{ (b) DUE TO Arteria sclerosis (c)		yes -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1958, to 1958, at 10 AM, from the causes and on the date stated above.	20f. (City or town) CRISFIELD, MARYLAND	(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from Nov. 12, 1958 , to Nov. 12, 1958 , that I last saw the deceased alive on Nov. 12, 1958 , and that death occurred at 10 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND					
ACTUAL SIGNATURE C. G. Rawley	M.D.	DATE SIGNED Nov. 12, 1958			
PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.	CRISFIELD, MARYLAND				
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 14, 1958	22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery	22d. LOCATION (City, town, or county) Marion Station, Md.	(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.	ADDRESS 12930	24a. REC'D BY REGISTRAR NOV 17 '58	24b. REGISTRAR'S SIGNATURE Carroll S. Kraus		



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12931 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12928

Reg. Dist. No.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of or its designated agent, prior to burial, cremation, or removal, and bury or cremate within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD, Pocomoke		c. LENGTH OF STAY IN lb Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home		d. STREET ADDRESS RFD, Pocomoke Rural	
e. IS RESIDENT ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THEODORE		First	Middle
4. DATE OF DEATH HORSEY		Month	Year
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Dixon		14. MOTHER'S MAIDEN NAME Harriett Horsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Horsey		Address Sally Taylor, RFD, Pocomoke, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line] (a), (b), (c) and (d) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 72 X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c)		INTERVAL BETWEEN DEATH AND DEATH 22 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year How 10:30 p.m 11-8 58 While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. INJURY OCCURRED <input type="checkbox"/> PLACE OF INJURY (Home, farm, factory, shop, office, bldg, etc.) County Road	
21. I certify that I took charge of the remains described above. Held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		(County) (State)	
ACTUAL SIGNATURE R. H. Johnson, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 11/10/58			
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Christ ME Cemetery		22d. LOCATION (City, town, or county) RFD, Pocomoke, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		24a. REC'D BY REGISTRAR DATE NOV 13 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

18. 11. 1913

Two-Stage Sampling

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12932

CERTIFICATE OF DEATH

12923

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F. D. Marion		c. LENGTH OF STAY IN 1b since 1904		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F. D. Marion		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MATTIE		First L.	Middle HUDSON	4. DATE OF DEATH November 3 1958	Month Day Year		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1878	9. AGE (In years lost birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John F. Jones		14. MOTHER'S MAIDEN NAME Eliza Crippin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs. Lawrence Burgess—R.F.D. Marion, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		is acute Dif of Heart				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Carcinoma of Breast				2 yrs	
DUE TO (b)		Metastasis of Liver & Lungs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Aug 1957 to Nov 3 1958, that I last saw the deceased alive on Oct 20 1958, and that death occurred at 4:30 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE George C. Coulbourn		M.D.		Marion Station, Md.			
PHYSICIAN'S NAME (Type) George C. Coulbourn, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 6, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Rehobeth Presbyterian		22d. LOCATION (City, town, or county) Rehobeth, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE C. S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMA. Page 5 may be retained for your records. **DEPUTY MEDICAL DIRECTOR:** Page 3 should be used as a burial-troupe permit. Give pages 1 and 2 with the State Board of Coroner's designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12960

1. PLACE OF DEATH o COUNTY <i>Comersey</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ortfield</i>		o STATE <i>Md.</i> b COUNTY <i>Comersey</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <i>Ortfield</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address)		d. STREET ADDRESS <i>609 Broadway</i>	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>R. E. Jackson</i>		First <i>R. E.</i>	Middle <i>Jackson</i>
4. DATE OF DEATH Month <i>Oct.</i> Day <i>3</i> Year <i>1958</i>		5. SEX <i>Fe.</i>	6. COLOR OR RACE <i>Negro</i>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>1901</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>1901</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>1901</i>
9. AGE (In years last birthday) <i>56 yrs</i>		9. AGE (In years last birthday) <i>56 yrs</i>	9. AGE (In years last birthday) <i>56 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Marion, N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Canis McCready</i>		14. MOTHER'S MAIDEN NAME <i>Laura Teague</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Doris Johnson-Marin Sta., Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Disease and Arteriosclerosis</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Burns</i>		DUE TO (b) <i>Burns</i> (c) <i>Burns</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION <i>None</i>		INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) <i>None</i> (County) <i>None</i> (State) <i>None</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William H. Coulbourn</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>William H. Coulbourn</i>		DATE SIGNED <i>Oct 4 1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 3 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Marion, N.C.</i>		22d. LOCATION (City, town, or county) <i>Marion, N.C.</i> (State) <i>None</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. Hart - Marion Sta., Md.</i>		ADDRESS <i>None</i>	
24a. REC'D BY REGISTRAR DATE <i>NOV 12 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Charles H. Hart</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

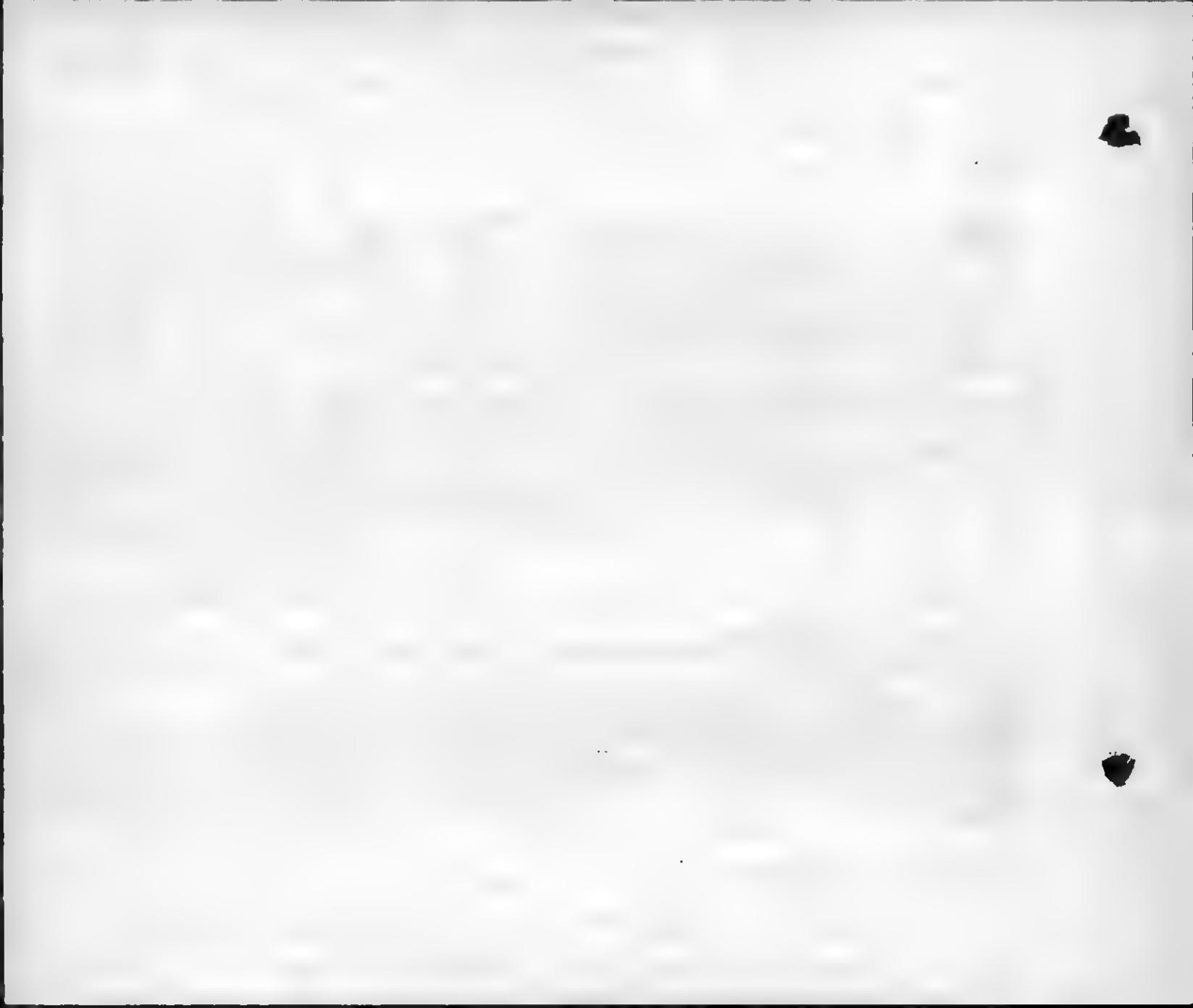
12933

CERTIFICATE OF DEATH

Reg. Dist. No. 12931

1. PLACE OF DEATH a. COUNTY Sonerset		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ORIOLE		c. LENGTH OF STAY IN 1b Life Time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ORIOLE	
3. NAME OF DECEASED (Type or print) First BESSIE		4. DATE OF DEATH Month II Day 6 Year 58 19	
5. SEX FEMALE		6. COLOR OR RACE COLORED	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/28	
9. AGE (In years birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. TIRE		10b. KIND OF BUSINESS OR INDUSTRY TEACHER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JEREMY MADDOX		14. MOTHER'S MAIDEN NAME ELLMORE MCCLIDE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 189-9-61146 17. INFORMANT KENNETH LANE PRINCESS ANNE, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral Vascular Accident INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) uremia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-1-58, 19, to 11-3-58, 19, that I last saw the deceased alive on 11-6-58, 19, and that death occurred at 7a M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Everett C. Sutter</i> PHYSICIAN'S NAME (Type) Everett C. Sutter ID		ADDRESS (Street, city or town, state) M.D. Dames Quarter, Maryland 11-7-58 DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF II/9/58	
22c. NAME OF CEMETERY OR CREMATORIAL ST. JAMES		22d. LOCATION (City, town, or county) CRIOLE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR. PRINCESS ANNE, MD		24a. REC'D BY REGISTRAR DATE NOV 10 '58	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-pass permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12932

12923

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>		b. COUNTY <u>SOMERSET</u>	
c. LENGTH OF STAY IN 1b <u>LIFETIME</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AT HOME</u>		d. STREET ADDRESS <u>CHESAPEAKE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or Print) <u>HATTIE OLEVIA LAWSON</u>	First <u>HATTIE</u>	Middle <u>OLEVIA</u>	Last <u>LAWSON</u>
4. DATE OF DEATH <u>NOV 3 1958</u>	Month <u>NOV</u>	Day <u>3</u>	Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 22-1871</u>
9. AGE (in years last birthday) <u>87 yrs</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. Hours <u>0</u>
13. FATHER'S NAME <u>ISAAC LAWSON</u>	14. MOTHER'S MARRIED NAME <u>MARGARET Dougherty</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Lena Hickman</u>	Address <u>Crisfield Md</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<u>Cerebral Hemorrhage - Acute Dis. of brain</u> + 2 subarachnoid <u>3 mos.</u>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		<u>Cerebral Arteriosclerosis - Chronic</u> <u>out. nephritis - Cerebrovascular</u> <u>years</u>	
(b)			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 31, 1958</u> to <u>Nov. 3 - 1958</u> , that I last saw the deceased alive on <u>Nov. 2 - 1958</u> , and that death occurred at <u>9:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Coulburn M.D.</u>	ADDRESS (Street, city or town, state) <u>MARION STA. MD. 11-3-58</u>		
PHYSICIAN'S NAME (Type) <u>George C. Coulburn M.D.</u>	DATE SIGNED <u>11-3-58</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Nov. 5-1958</u>	22b. DATE THEREOF <u>Nov. 5-1958</u>	22c. NAME OF CEMETERY OR Crematory <u>Asbury Methodist</u>	22d. LOCATION (City, town, or county) <u>Crisfield</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Hinman</u>		ADDRESS <u>Crisfield</u>	24a. REC'D BY REGISTRAR DATE NOV 6 '58
			24b. REGISTRAR'S SIGNATURE <u>C. L. Hinman</u>

1
HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Log in
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be given to the funeral director for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be left with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be used with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

79

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12934

12933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) a. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 82 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 CRISFIELD		d. STREET ADDRESS 1 FIRST STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KATHRYN		First KATHRYN	Middle C.	4. DATE OF DEATH NOVEMBER	Month NOVEMBER	Day 6	Year 1958
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1876	9. AGE (In years lost/birthday) 82 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Christy				14. MOTHER'S MAIDEN NAME Betsy Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT ELOISE MASON,		Address CRISFIELD, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9		DUE TO <i>terminal obstruction</i>					
Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>carcinoma, bowel</i>					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ACTUAL SIGNATURE <i>C. G. Rawley</i>		ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND DATE SIGNED 1958					
PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.		CRISFIELD, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE <i>Other & Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12935

CERTIFICATE OF DEATH

12934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SHELLTOWN		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMORIAL HOSP.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle -----	Last MENZEL	4. DATE OF DEATH	Month NOVEMBER	Day 3	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-1907	9. AGE (In years last birthday) 50	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT MENZEL		14. MOTHER'S MAIDEN NAME SUSANNA ECFORT					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 212-40-8656		17. INFORMANT HAZEL MENZEL		Address SHELLTOWN, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO		<i>Acute dil. of heart</i>				INTERVAL BETWEEN ONSET AND DEATH minutes	
		<i>Dissecting aneurysm abd. aortic</i>				10 hrs.	
		<i>Arterio sclerosis</i>				3	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Demiglogia incomplete						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 3, 1958 to Nov. 3, 1958 that I last saw the deceased alive on Nov. 3, 1958 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND						DATE SIGNED	
ACTUAL SIGNATURE C. G. Rawley							
PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.							
22a. BUR. AL. CREMATION, REMOVAL (Specify) Rural		22b. DATE THEREOF 11-7-58		22c. NAME OF CEMETERY CRISFIELD St. Paul Methodist		22d. LOCATION (City, town, or county) Rural Marion, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Watson		ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE John S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be deleted for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. To be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12936 CERTIFICATE OF DEATH

Reg. Dist. No. 261-12935

1. PLACE OF DEATH o COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station		c. LENGTH OF STAY IN 1b RURAL and give nearest town Family	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion Station X	
3. NAME OF DECEASED (Type or print) Addie Outten		d. STREET ADDRESS —	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 29-1880	
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months — Days — Hours — Min —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Crisfield MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEVIN		14. MOTHER'S MAIDEN NAME HARRIT STERLING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO. —	
17. INFORMANT Rachel Jones		Address Crisfield, Md. Pt. 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute dilation of heart (Coronary death) 12 hrs			
592 X DUE TO Chronic diet. nephritis & C. myocarditis 7 years			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) General arterio- (c) clerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. Nov 3, 1958 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) — (County) — (State) —	
21. I certify that I attended the deceased from Nov 3, 1958 to Nov 4, 1958 that I last saw the deceased alive on Nov 4, 1958 , and that death occurred at 2:00 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE George C. Coulbourn M.D.		ADDRESS (Street, city or town, state) Marion Sta. Md. DATE SIGNED 11-6-58	
PHYSICIAN'S NAME (Type) GEORGE C. COULBOURN MD MARION STATION MD.			
22a. BUR AL, CREMAT. ON Burial		22b. DATE THEREOF Nov. 7, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Family		22d. LOCATION (City, town or county) Marion Station (State) —	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward Marion Sta. Md.		ADDRESS —	
24a. REC'D BY REGISTRAR NOV 12 '58		24b. REGISTRAR'S SIGNATURE —	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

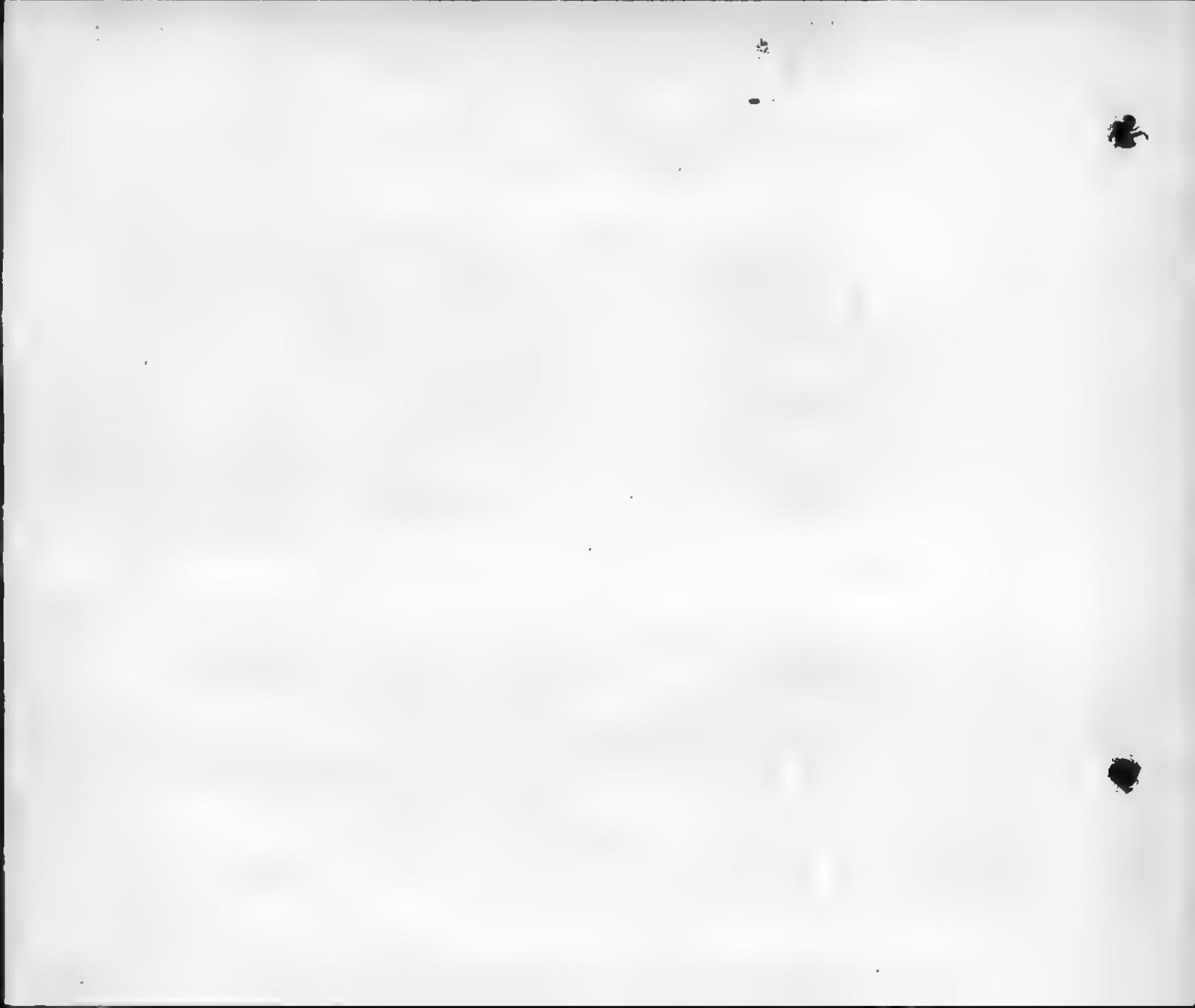
12937

CERTIFICATE OF DEATH

12936

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE		c. LENGTH OF STAY IN 1b TWO MONTHS		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PRINCESS ANNE		e. STREET ADDRESS 335 HAMPDEN AVE		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRINCESS ANNE			
3. NAME OF DECEASED (Type or print) EMMA		First MARIE		Middle ROBERTS		4. DATE OF DEATH II 3 19 58		Month Day Year	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/58		9. AGE (In years lost birthday) yrs 2		10. IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME SHARMAN ROBERTS		14. MOTHER'S MAIDEN NAME BESSIE MULLIN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT BESSIE MULLIN PRINCESS ANNE, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Virus infection		INTERVAL BETWEEN ONSET AND DEATH 1wk			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Marked Malnutrition + Dehydration		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury. Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 27 1958 to Nov 3 1958 , that I last saw the deceased alive on Nov 3 1958 , and that death occurred at 7:30 AM , from the causes and on the date stated above.		ACTUAL SIGNATURE A. C. Lewis, M.D.		ADDRESS (Street, city or town, state) Princess Anne, Md.		DATE SIGNED 11/3/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF II/4/58		22c. NAME OF CEMETERY OR CREMATORIAL MT CARMAL		22d. LOCATION (City, town, or county) (State) PRINCESS ANNE MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES, JR.		ADDRESS PRINCESS ANNE, MD		24a. REC'D BY REGISTRAR NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be dated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12938 CERTIFICATE OF DEATH

12937

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Accomack				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 3 months				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA McCready Hospital		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle THOMAS	Last SCOTT			
4. DATE OF DEATH November 30,	Month 1958	Day	Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1880			
9. AGE (In years from birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	11. KIND OF BUSINESS OR INDUSTRY House Painting	12. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME William D. Scott	14. MOTHER'S MAIDEN NAME Willie Smith	15. CITIZEN OF WHAT COUNTRY USA				
16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Olevia B. Scott, Wachapreague, Va.	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from <u>Nov. 30, 1958</u> , to <u>Dec. 30, 1958</u> , that I last saw the deceased alive on <u>Nov. 30, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sarah M. Peyton</u> M.D. <u>33 W. Main St.</u> DATE SIGNED <u>12/2/58</u>						
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton, M. D.</u> Crisfield, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Edge Hill Cemetery	22d. LOCATION (City, town, or county) Accomac, Virginia (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland			24a. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Clara S. Trahan</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12939

CERTIFICATE OF DEATH

12938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				c. LENGTH OF STAY IN 1b 20 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
f. STREET ADDRESS 522 S. Somerset Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Sallie	Middle Lankford	Last Shields	4. DATE OF DEATH Nov. 4	Month Nov.	Doy 19 58
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1866	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin F. Lankford		14. MOTHER'S MAIDEN NAME Amanda Porter		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO.		17. INFORMANT		Address Miss Amanda Lankford Princess Anne, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		(a) Coronary thrombosis DUE TO 420.1				2 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Chronic myocarditis DUE TO				2 yrs.	
		(c) Arteriosclerosis (General)				10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1958, to Nov 4, 1958 , that I last saw the deceased alive on Aug 3, 1958 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 20 Prince William St. Nov 5/8							
ACTUAL SIGNATURE B. Frank Giganti, M.D.		DATE SIGNED 8/5/58					
PHYSICIAN'S NAME (Type) B. FRANK GIGANTI		22. BURIAL, CREMATION, REMOVAL (Specify) burial					
22b. DATE THEREOF II-6-1958		22c. NAME OF CEMETERY OR CREMATORIAL Manokin Presbyterian		22d. LOCATION (City, town, or county) Princess Anne, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE George Nelson		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE George S. Meaus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PN3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

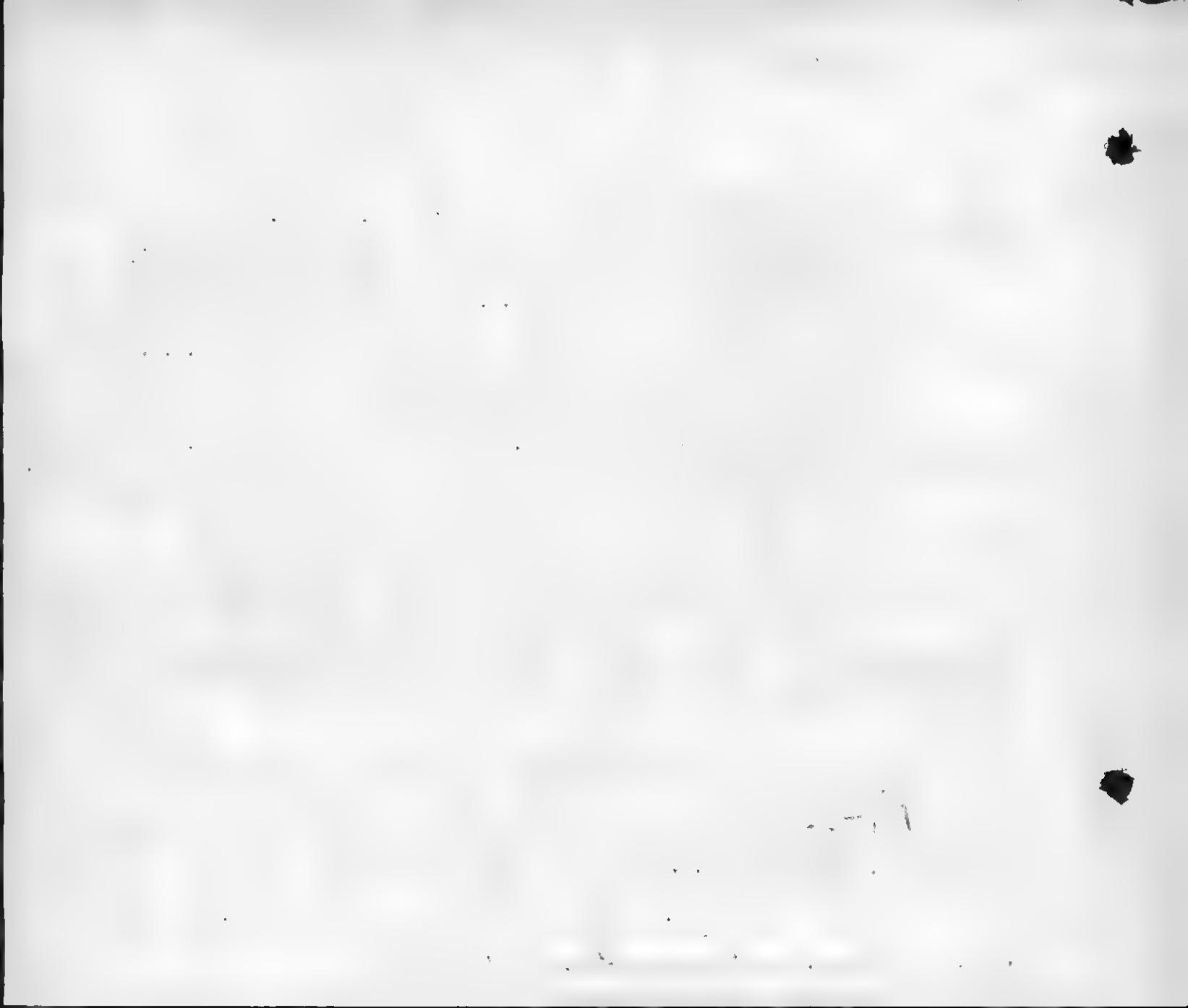
VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12940 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12939

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		Reg. Dist. No	
a. COUNTY		a. STATE Maryland		b. COUNTY Somerset	
Somerset		Maryland		Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Princess Anne				Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		Linden Ave., Ext'd.			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
		Charles	Robert	Siddons	Month
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (at birthday)
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 3, 1884	73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired farmer & carpenter		Farming Retired		South Dakota	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Frederick Siddons		Kate Hawley		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT	
		220-12-2264		Mrs. Ethel Siddons - Linden Ave.-Princess Anne, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address			
PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a)		Acute coronary occlusion			
4.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>R. H. Johnson</i>		MD CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R. H. Johnson, M.D.		DATE SIGNED 12/1/58			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/58		22c. NAME OF CEMETERY OR CREMATORIAL St. Andrews Episcopal	
22d. LOCATION (City, town, or county) Princess Anne, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Johnson, Princess Anne, Md.</i>		ADDRESS		24a. REC'D. BY REGISTRAR 12/2/58	
				24b. REGISTRAR'S SIGNATURE C. J. H. Johnson	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12924

CERTIFICATE OF DEATH

Reg. Dist. No.

12940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		d. STREET ADDRESS 701 W. Main St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 701 W. Main St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) DAVID FRANKLIN SNEADE		First	Middle	Last	4. DATE OF DEATH Nov. 19	Month	Day	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 11, 1907	8. AGE (In years lost birthday) 50 yrs.	9. IF UNDER 1 YEAR; IF UNDER 24 HRS, Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heating & Plumbing		10b. KIND OF BUSINESS OR INDUSTRY For Himself		11. BIRTHPLACE (State or foreign country) Rhodes Point, Md.		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME David F. Sneade				14. MOTHER'S MAIDEN NAME Mary Bradshaw				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO W W II 577-26-4357		17. INFORMANT Mrs. Angeline M. Sneade- Crisfield, Md.		Address 701 W. Main St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X		DUE TO Topic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH one week				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Inanition				There no known five mo.		
(c) DUE TO Esophageal Carcinoma of Tongue								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crisfield, Md. (County) (State) Nov 19 9-4-8.		
21. I certify that I attended the deceased from June 1958, to Dec 1958, that I last saw the deceased alive on Nov. 16, 1958, and that death occurred at 6:15 PM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 11/22/58		
ACTUAL SIGNATURE A. N. Bass								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery		22d. LOCATION (City, town, or county) Crisfield, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 2 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Bass		



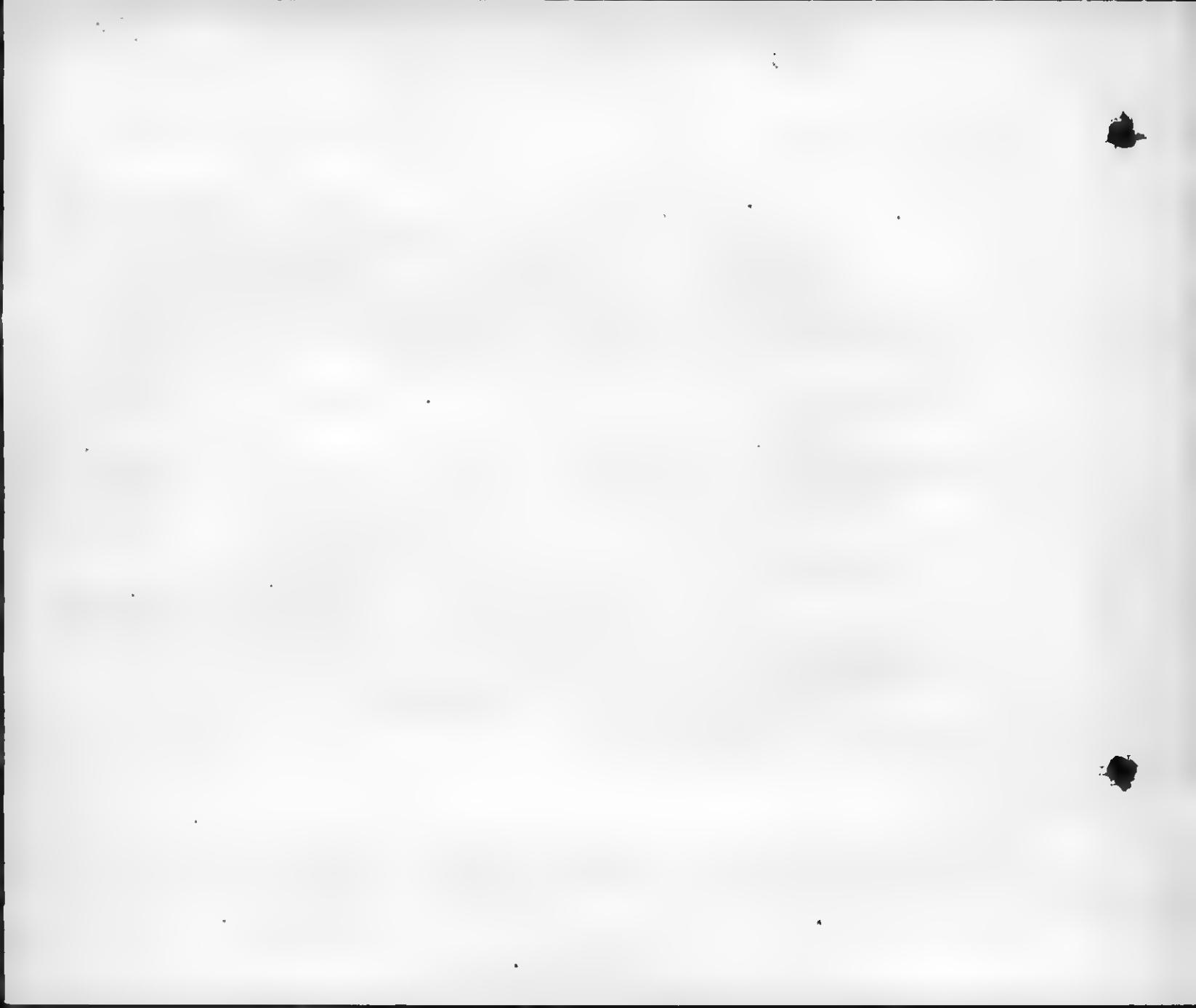
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 12941 Items 7, 8, 9 File 6235 11-13-58 et

CERTIFICATE OF DEATH

12941

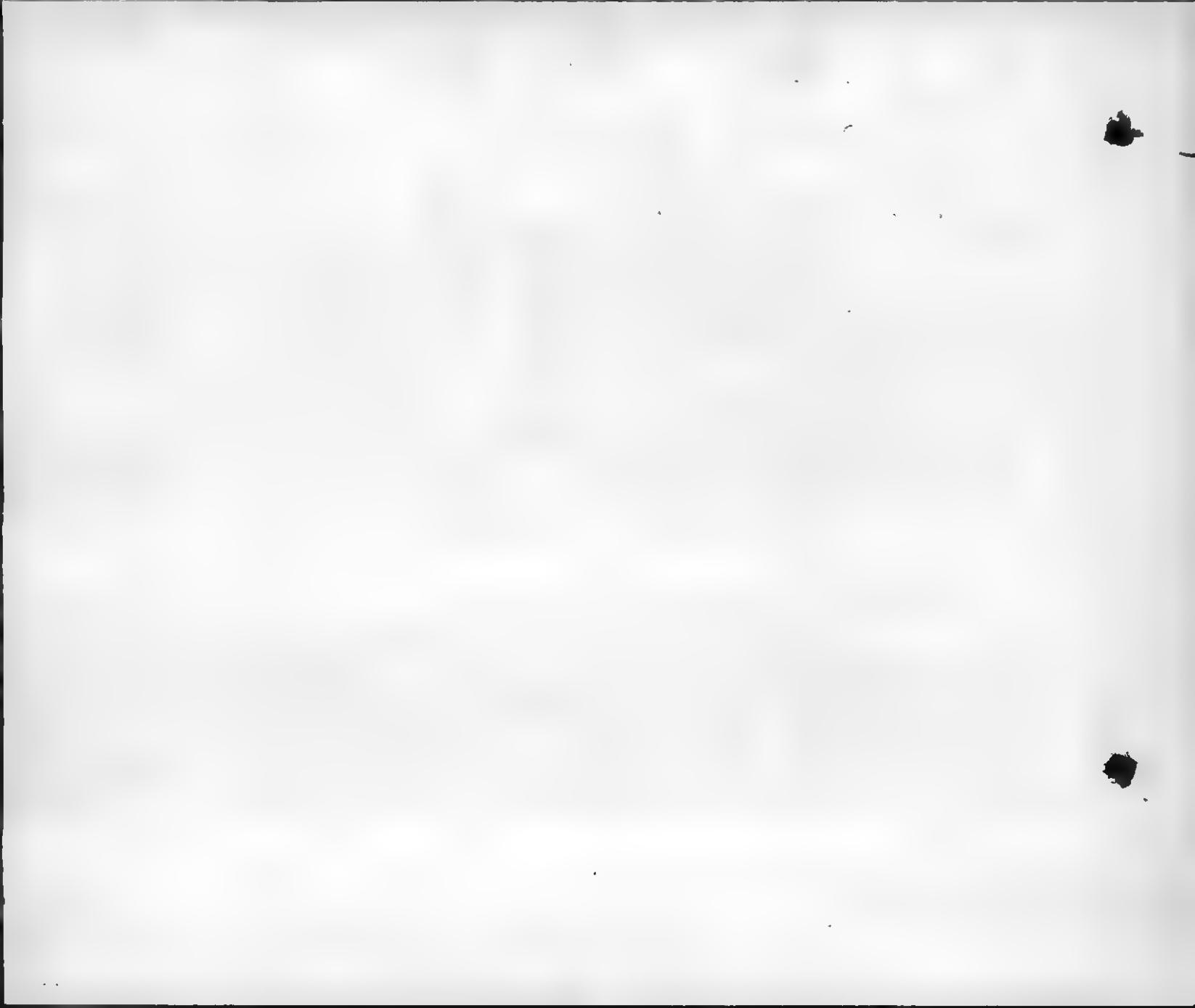
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.		e. STREET ADDRESS 138 MARYLAND AVENUE	
3. NAME OF DECEASED (Type or print) ABRAHAM		First ABRAHAM	Middle SOMERS
4. DATE OF DEATH NOVEMBER 2 1958	Month NOVEMBER	Day 2	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1872 MAY 12, 1884 86 yrs
9. AGE (in years (or birthday) 86 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ABRAHAM SOMERS		14. MOTHER'S MAIDEN NAME SALLY NELSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Spanish-American	17. INFORMANT None ANNIE BURKE
Address CRISFIELD, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 INTERVAL BETWEEN ONSET AND DEATH Immediately			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO 10 years (c) Hypertrophic Prostate & urinary retention DUE TO 1 wt.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Suprapubic cystostomy for retention			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CRISFIELD, MARYLAND
20f. (City or town) CRISFIELD		(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from Oct. 25, 1958 to Nov. 2, 1958 , that I last saw the deceased alive on Nov. 2, 1958 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE SARAH M. PEYTON		ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND	
PHYSICIAN'S NAME (Type) SARAH M. PEYTON, M.D.		DATE SIGNED 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5, 1958	
22c. NAME OF CEMETERY OR CREMATORIUM Crisfield Cemetery		22d. LOCATION (City, town, or county) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. ADDRESS Bradshaw & Sons--Crisfield, Md.	24b. REC'D BY REGISTRAR NOV 1 1958
		24c. REGISTRAR'S SIGNATURE Arthur S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12942	
Item 1 FEB 26 12-3-58 et											
12942 CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY SOMERSET					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD			d. STREET ADDRESS TYLER STREET		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO.					d. STREET ADDRESS TYLER STREET					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First ANNA	Middle MAE	Last STERLING	4. DATE OF DEATH	Month NOVEMBER	Day 21	Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 3-1900 58	9. AGE (In years last birthday) 58 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. IF UNDER 24 HRS Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Known					14. MOTHER'S MAIDEN NAME John Known						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No					16. SOCIAL SECURITY NO	17. INFORMANT Pyde Sterling, Crisfield Md	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		Month Nov	Day 20	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) CRISFIELD, MARYLAND	20f. (City or town) CRISFIELD, MARYLAND	(County) CRISFIELD, MARYLAND	(State) MARYLAND		
21. I certify that I attended the deceased from Nov 20, 1958 to Nov 21, 1958 , that I last saw the deceased alive on Nov 20, 1958 , and that death occurred at 7:45 M, from the causes and on the date stated above. ACTUAL SIGNATURE Sarah M. Peyton M.D. CRISFIELD, MARYLAND										ADDRESS (Street, city or town, state) CRISFIELD, MARYLAND	DATE SIGNED 1958
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF Nov 24-58	22c. NAME OF CEMETERY OR CREMATORIAL WARD'S	22d. LOCATION (City, town, or county) MARION, SOM, MD.	(State) MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE Charles Edward Marion Md.					ADDRESS Charles Edward Marion Md.	24a. REC'D BY REGISTRAR DATE DEC 1 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kinne				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: this certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12943

CERTIFICATE OF DEATH

12943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VIRGINIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		b. COUNTY TANGIER		
c. LENGTH OF STAY IN 1b 1 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANGIER		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. McCREADY MEMO. HOSP.		d. STREET ADDRESS 83x-3		
3. NAME OF DECEASED (Type or print) LILLIE		First THOMAS	Middle THOMAS	
4. DATE OF DEATH NOVEMBER 18 1958	Month NOVEMBER	Day 18	Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-29-1883	
9. AGE (In years last birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME WILLIAM BROWN	14. MOTHER'S MAIDEN NAME BRITTANA BRYANT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT VIRGINIA CHARNOCK, TANGIER, VA.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Previous Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease/Hypertension			INTERVAL BETWEEN ONSET AND DEATH One hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/17 1958 to 11/18 1958 , that I last saw the deceased alive on 11/15 1958 , and that death occurred at 2 P.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>A. N. Barr</i>	PHYSICIAN'S NAME (Type) A. N. BARR, M.D.	M.D.	ADDRESS (Street, city or town, state) Campbell, Md.	DATE SIGNED 11/18/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 21-1958	22b. DATE THEREOF Nov. 21-1958	22c. NAME OF CEMETERY OR CROWNING Family Cemetery	22d. LOCATION (City, town, or county) Tangier	(State) Va.
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. G. Webster</i>	ADDRESS <i>Graveside Adm.</i>	24a. REC'D BY REGISTRAR DATE NOV 20 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Pearce</i>	

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12944
CERTIFICATE OF DEATH

12944
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY SOMERSET MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARION STATION	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EDW. W. MCCREADY MEMO. HOSP.			d. STREET ADDRESS 1		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First RALEIGH	Middle M	Last WARD	4. DATE OF DEATH NOVEMBER	Month 6 Day 19 Year 58
5. SEX MALE	6. COLOR OR RACE WHTTE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-1878	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HOPE WARD			14. MOTHER'S MAIDEN NAME INDIA PURNELL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT SULA WARD	Address MARION, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Uremia - Acute Dil. of Heart Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) C. Inf. nephritis - C. Hypertension - DUE TO General arteriosclerosis (c)					
INTERVAL BETWEEN ONSET AND DEATH 1 week					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month Nov. Day 4	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 4, 1958 to Nov. 6, 1958 , that I last saw the deceased alive on Nov. 5, 1958 , and that death occurred about 11:50 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE George C. Coulburn, M.D. ADDRESS (Street, city or town, state) MARION, MARYLAND DATE SIGNED					
PHYSICIAN'S NAME (Type) G. C. COULBOURN, M.D. , MARION, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 9, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	22d. LOCATION (City, town, or county) Crisfield, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.			24a. REC'D BY REGISTRAR DATE NOV 10 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

STATE OF SOUTH DAKOTA
CERTIFICATE OF DEATH

1962

